STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 01 B. WING	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/11/11 Facility Number: 000167 Provider Number: 155266 AIM Number: 100273740 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Life Care Center of Fort Wayne was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type III (200) construction and was fully	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 01 B. WING	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	sprinklered. The facility has a fire alarm system with smoke detection in the corridors and areas open to the corridors. The facility has a capacity of 125 and had a census of 75 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/17/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0025 SS=F	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 7 of 7 smoke barrier walls with penetrations were maintained	K0025	K025 1.Foam removed from all effected areas and replaced with fire caulk. 2.Maintenance Director will ensure only fire caulk is used for any smoke barriers. 3.Systematic Change: Maintenance Director has a supply of fire caulk in house and will only use this product in areas that are designated as smoke	11/10/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 01 B. WING	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to provide the one half hour fire resistance of each smoke barrier. LSC Section 19.3.7.3 requires smoke barriers to be constructed in accordance with LSC Section 8-3. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect all occupants. Findings include: Based on observations with Maintenance Director on 10/11/11 from 1:45 p.m. to 1:47 p.m., the smoke barrier wall above the drop down ceiling in the Therapy hall and Beecher hall had seams sealed with expandable foam. Also, one of the two penetrations in the Beecher hall smoke barrier wall was sealed with expandable foam. Based on interview with the Maintenance		barriers. 4.The Maintenance Director or designee is responsible for ensuring only fire caulk is used in the drop down ceiling or any other areas designated as smoke barriers. 5.Date of Completion: November 10, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 01 B. WING	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Director at the time of the observations, expandable foam has been used above the drop down ceiling at all the smoke barrier walls. 3.1-19(b)			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 1. Based on observation and interview, the facility failed to ensure 1 of 1 roll down doors at the opening in the kitchen wall, a hazardous area, would self close upon activation of the fire alarm system. This deficient practice could affect all residents in the Preston dining room. Findings include:	K0029	K029 1.Cited sliding door was added to the fire alarm system on 10/26/11. All other doors cited were repaired on 10/12/11. 2.Maintenance Director or designee will review doors as part of daily rounds to ensure proper latching and results will be supplied to Executive Director for approval for next 90 days. 3.Systematic Change: Drop down door added to fire alarm system to automatically close and will be audited with entire system during each drill. 4.The Maintenance Director is responsible for all documentation to support plant operations to include proper fitting of all doors. Daily rounds will be documented and supplied to the Executive Director for approval. Date of Completion: October 26, 2011	10/26/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 01 B. WING	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on observation with the Maintenance Director on 10/11/11 at 12:30 p.m., the Preston dining room was open to the corridor and met the requirements for a space to be allowed to be open to the corridor. The wall around the dining room is therefore, considered to be the corridor wall. There was a pass through opening in the corridor wall between the dining room and the kitchen. The opening was protected with a rolling door with a fusible link. Based on interview with Maintenance Director at the time of observation, the rolling fire door does not close upon activation of the fire alarm. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure the corridor door to 2 of 3 storage rooms with combustibles measuring over 50 square feet in size, and 1 of 1 laundry rooms were provided with a self closing device and a door that latches into the door frame. This deficient practice could affect any resident			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 01 B. WING	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	near the resident phone room and evacuated through the service hall. Findings include: a. Based on observation with the Maintenance Director on 10/11/11 at 12:35 p.m., the corridor door to the "resident phone room storage room" containing boxes of resident files and cardboard boxes, measuring over 50 square feet in size, lacked a self closing device. The Maintenance Director confirmed the storage room measured over fifty square feet. b. Based on observation with the Maintenance Director on 10/11/11 at 1:07 p.m., the self closer was broken on the corridor door to the service hall housekeeping supply storage room, measuring over fifty square feet, containing cleaning chemical and cardboard boxes. The Maintenance Director confirmed the storage room measured over fifty square feet c. Based on observation with the Maintenance Director on 10/11/11 at 1:07, the corridor door entering the dryer side of the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 01 B. WING	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	laundry room failed to latch into the frame. This was acknowledged by the Maintenance Director at the time of observation. 3.1-19(b)			
K0050 SS=F	Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 2 of the last 4 completed quarters. This deficient practice could affect all occupants. Findings include:	K0050	K050 1.Fire drills are required each month on each shift and are to be fully documented and participated in by all staff members. A sign in for participation will be completed by the staff involved and all drills will be recorded in the TELS automated system upon completion. 2.Maintenance Director will ensure TELS is updated weekly or as needed with record of fire drills and results will be provided at monthly Process Improvement Meeting. 3.Systematic Change: Maintenance Director will print TELS reports weekly for the Executive Director to review to ensure all expected fire drills are completed on time and recorded correctly. 4.The Maintenance Director is responsible for ensuring fire drills are completed each month during each shift and to record the outcomes in the TELS	11/10/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 01 B. WING	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on record review of the untitled fire drill form with the Maintenance Director on 10/11/11 at 10:40 a.m., there was no record of a second shift fire drill for the third quarter of 2011 and a second shift fire drill for the fourth quarter of 2010. Based on an interview with the Maintenance Director at the time of record review, no other documentation was available for review to show these drills had been conducted. 3.1-19(b) 3.1-51(c)		system and keep a copy of the sign in sheet from each fire drill. 5.Date of Completion: November 10, 2011	
K0062 SS=E	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on observation and interview, the facility failed to ensure 2 of 2 sprinkler gauges in the Preston Hall boiler room were tested every five years. NFPA 25, Section 2-3.2 states gauges shall be replaced every five years or tested every five years by	K0062	K062 1.Sprinkler gauges replaced on 10/19/11. 2.An audit of all sprinkler gaugess has been completed with no other issues noted. 3.Systematic Change: An audit of all sprinkler gauges will be completed annually by the Maintenance Director each September. 4.The Maintenance Director is responsible for plant safety and will complete sprinkler gauge audits Annually every September. Date of Completion: 19 October 2011	10/19/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 01 B. WING	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	comparison with a calibrated gauge. This deficient practice could affect any occupant receiving sprinkler protection from the Preston boiler room. Findings include: Based on observation with the Maintenance Director on 10/11/11 at 12:45 p.m., the two sprinkler gauges in the Preston hall boiler room had a date of 2005. Based on an interview with the Maintenance Director at the time of observation, he was unable to verify the sprinkler gauges have been calibrated or replaced since 2005. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 01 B. WING	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 areas used for transferring of oxygen was provided with continuous mechanical ventilation. This deficient practice could affect any resident near the oxygen tranferring room near the Preston hall nurses' station. Findings include: Based on observation with the Maintenance Director on 10/11/11 at 12:42 p.m., the oxygen transfilling/storage room contained several large cylinders of liquid oxygen. The mechanical ventilation in the oxygen room	K0143	K143 1.Motor in the ventilation system of the oxygen supply room replaced and inspected for operation on 11/2/11. 2.Ventilation fan operation added to daily Maintenance Director rounds and documentation will be kept for no less than six months verifying fan is operational on a daily basis. 3.Systematic Change: Ventilation fan in oxygen supply room has been added to the daily round checklist for the Maintenance Director. If an issue is discovered it will be reported to the Executive Director immediately and proper repairs will be ordered. 4.The Maintenance Director is responsible for plant operations to include the function of all exhaust fans and safety equipment. The Maintenance Director will check the operation of the ventilation fan daily as part of his daily walkthrough checklist. 5.Date of Completion: November 2, 2011	11/02/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 01 B. WING	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	could not be heard and did not appear to be running. This was confirmed by the Maintenance Director after he placed his hand near the ceiling vent. 3.1-19(b)			
K0144 SS=E	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure 1 of 3 emergency generators was capable of supplying electrical power within 10 seconds of the failure of normal power providing power to the emergency lighting systems. LSC 7.9.2.3 and NFPA 99, Health Care Facilities, 3-4.1.1.8 requires the generator set(s) shall have sufficient capacity to pick up the load and meet the minimum frequency and voltage stability requirements of the emergency system within 10 seconds after loss of normal power. This deficient practice affects all occupants receiving power from the Beecher hall generator.	K0144	K144 1.Generator load did not power up in 10 seconds because of the starter on the unit. Starter replaced on 10/14/11. Letter from NIPSCO confirming they are to supply our emergency power was delivered by them on 10/17/11. 2.Complete generator system is currently being replaced by a centralized system through SafeCare with a completion date 12/2/11.. 3.Generator audits will be completed using Life Safety and corporate guidelines monthly by the Maintenance Director.. 4.The Maintenance Director is responsible for the safety of the plant and will audit generator systems monthly with results turned over to the Executive Director. 5.Date of Completion: 14 October 2011	10/14/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 01 B. WING	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on review of the generator log titled "Exercise Generator (under load)" with the Maintenance Director on 10/11/11 at 10:57 a.m., the monthly load test record indicated the transfer of power from the main source to the emergency generator for the generator located on Beecher hall took twenty five seconds in September 2011. Based on an interview with the Maintenance Director at the time of record review, he was aware of the problem and is awaiting a part. 3.1-19(b) 2. Based on interview and record review, the facility failed to ensure the off site fuel source for 2 of 3 emergency generators was from a reliable source. NFPA 110 1999 Edition, Standard for Emergency and Standby Power Systems, Chapter 3, Emergency Power Supply (EPS), 3-1.1 Energy Sources states the following energy sources shall be permitted for use for the emergency power supply			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 01 B. WING	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(EPS): a) Liquid petroleum products at atmospheric pressure b) Liquefied petroleum gas (liquid or vapor withdrawal) c) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high (e.g., due to earthquake, flood damage or demonstrated utility unreliability), on-site storage of an alternate energy source sufficient to allow full output of the emergency power supply system (EPSS) to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. CMS (Centers for Medicare/Medicaid Services) requires a letter of reliability from the natural gas vendor regarding the fuel supply that must contain the following: 1. A statement of reasonable reliability of the natural gas delivery. 2. A brief description that supports the statement regarding			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155266	A. BUILDING 01 B. WING	10/11/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF FORT WAYNE	1649 SPY RUN AVENUE FORT WAYNE, IN46805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	the reliability. 3. A statement that there is a low probability of interruption of the natural gas. 4. A brief description that supports the statement regarding the low probability of interruption, 5. The signature of a technical person from the natural gas provider. This deficient practice could affect all residents, staff and visitors. Findings include: Based on interview with the Maintenance Supervisor during the record review process on 10/11/11 at 11:05 a.m., the facility was unable to provide a letter from their natural gas provider (NIPSCO) stating the fuel source for the generators is a "reliable source". 3.1-19(b)			